

**DIVISION OF TENNCARE LONG TERM SERVICES AND SUPPORTS OPERATIONAL PROTOCOL**

<b>PROTOCOL TITLE: CHOICES AND EMPLOYMENT AND COMMUNITY FIRST CHOICES ARPA FMAP PROVIDER REFERRAL INCENTIVES</b>
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<b>EFFECTIVE DATE: NOVEMBER 2, 2021</b>
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**This protocol sets forth specific requirements and expectations related to the referral incentive available to eligible CHOICES and Employment and Community First (ECF) CHOICES Home and Community-Based Services (HCBS) providers under Tennessee’s American Rescue Plan Act (ARPA) Federal Medical Assistance Percentage (FMAP) Initial Spending Plan.**

**A. Background and Objectives**

Authorized under Section 9817 of the American Rescue Plan Act of 2021 (ARPA) (Pub. L. 117-2) and guidance set forth in SMD# 21-003, issued on May 13, 2021, this funding opportunity for enhanced HCBS provides qualifying states with a temporary ten (10) percentage point increase to the FMAP for certain Medicaid HCBS expenditures incurred between April 1, 2021 and March 31, 2022. The non-recurring enhanced HCBS FMAP funds earned must be spent by March 31, 2024, and must be spent exclusively on Medicaid HCBS to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021. Utilizing extensive feedback from HCBS stakeholders, Tennessee identified three (3) key areas of FMAP funding opportunity:

1. Improved access to HCBS for persons supported and family caregivers;
2. Investments in the HCBS workforce capacity and competency; and
3. Investments in HCBS provider capacity.

One of the greatest challenges HCBS providers face in increasing their capacity to provide supports to additional people is the up-front investment involved in screening, hiring, training, and retaining new staff. In that regard, the payment of a new referral incentive for specified types of HCBS could help to offset these up-front costs more quickly, and greatly enhance providers’ capacity to prepare to serve additional program participants.

This protocol outlines the referral incentive, the criteria for provider eligibility, requirements for provider use, and requirements for MCO reporting of incentive funds.

**B. Provider Referral Incentive**

The provider referral incentive consists of non-recurring provider payments as part of the Medicaid reimbursement for specified types of services: residential, personal care, individual employment supports and/or specified services to increase independence and integration.

Specifically, this incentive payment is available to providers who accept new referrals for the following services:

	<b>Residential</b>	<b>Personal Care</b>	<b>Individual Employment</b>	<b>Independence/Integration</b>
<b>CHOICES</b>	<ul style="list-style-type: none"> <li>• Community Living Supports (CLS), including Community Living Supports-Family Model (CLS-FM)</li> <li>• Adult Care Home</li> <li>• Assisted Care Living Facility</li> </ul>	<ul style="list-style-type: none"> <li>• Attendant Care</li> <li>• Personal Care Visits</li> </ul>		
<b>ECF CHOICES</b>	<ul style="list-style-type: none"> <li>• CLS, including CLS-FM</li> <li>• Intensive Behavioral Community Transition and Stabilization Services (IBCTSS)<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Personal Assistance</li> <li>• Supportive Home Care</li> <li>• IBFCTSS<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Individual Employment Supports (Exploration, Discovery, Job Development Plan/Self-Employment Plan/Start-Up, Job Coaching, Integrated Employment Path Services)</li> </ul>	<ul style="list-style-type: none"> <li>• Community Integration Support Services (CISS)</li> <li>• Independent Living Skills Training (ILST)</li> </ul>

There are two components of the provider referral incentive payment.

1. Providers will be eligible for a \$500 “Initiation of New Services” payment upon acceptance of a new referral and initiation of services in accordance with the member’s person-centered support plan (PCSP), including the frequency, intensity, scope and duration of services. If a member’s PCSP includes multiple services in the same service type, e.g., Personal Care Visits and Attendant Care in CHOICES, or CISS and ILST in ECF CHOICES, the provider must implement both services in accordance the frequency, intensity, scope and

<sup>1</sup> NOTE: Although unique modifiers have been established for purposes of claiming the incentive for IBCTSS and other CLS/CLS-FM services, providers are eligible for only one incentive per member across all residential service types.

<sup>2</sup> NOTE: Although unique modifiers have been established for purposes of claiming the incentive for IBFCTSS and other ECF CHOICES Personal Care service types, providers are eligible for only one incentive per member across all personal care service types.

duration of services in the PCSP. Generally, Individual Employment Supports will be initiated one-at-a-time, but by acceptance of the referral, the Provider commits to providing each of the services in a continuous manner, as they are needed.

2. Providers will be eligible for a \$500 “Continuity of Care” payment following the successful continuous staffing and provision of the service in accordance with the PCSP (including the frequency, intensity, scope and duration of services) for at least six months. To qualify for this payment, at least 90% of the service during the six-month period must have been provided.<sup>3</sup> Providers are responsible for monitoring their compliance prior to submission of a claim, and for submitting a claim for this payment only if the conditions of payment are met. Compliance will be subject to audit, and to follow-up as appropriate if claims are determined to have been submitted in error.

For Individual Employment Supports, the Continuity of Care payment may take into account the provision of multiple Individual Employment Supports (e.g., Discovery, Job Development Plan, Job Start-Up, Job Coaching) across the six-month period. For pre-employment supports, the provision of services is counted only if the outcome-based deliverable for the service was achieved.

### **Limitations**

A provider must be eligible for the Initiation of New Services payment in order to qualify for the Continuity of Care payment.

In general, only one referral incentive shall be provided per member per service type (residential, personal care, individual employment or independence/integration). On a case-by-case basis, and only under extenuating circumstances, a provider may be eligible for an incentive payment for a member who requests to change agencies only for the first transfer to a new provider agency. Any subsequent transfers by the member to a new provider agency will not result in eligibility for the incentive payments.

A provider shall not receive multiple incentive payments for initiating multiple services within a service type. For example, once an employment provider begins providing individual employment supports, it is expected that the employment provider will continue to maintain staffing to provide additional individual employment supports the member may need.

### **C. Effective Dates**

This incentive is also available retroactively to providers who have continued to make investments during the COVID-19 Public Health Emergency (PHE) by accepting referrals for any

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<sup>3</sup> For purposes of the 90% threshold, only missed visits reduce the percentage. EVV services will be monitored through EVV systems (PA, AC, PC, IBFCTSS and SHC) and non-EVV services (CLS, CLS FM, IBCTSS, CISS, Employment, and ILST) will be tracked based on the plan and documentation from Coordinators and providers.

services that meet the criteria in this protocol and which were initiated on or after April 1, 2021. These providers are also eligible for the additional Continuity of Care incentive payment for any services which were continuously staffed for six months post-service initiation.

Subject to the continued availability of Enhanced HCBS FMAP funding, these payments will continue to be available for services initiated through March 31, 2024.

#### **D. Provider Use of Incentive Funds**

Funds are intended to help offset provider costs related to increased staff capacity to deliver additional HCBS, e.g., pre-service training, background checks, etc. Funds may be used by the provider to offer recruitment and/or retention bonuses to its frontline staff—in order to help ensure both the sufficiency and stability of the frontline workforce and the return on investment.

#### **E. Provider Eligibility Criteria for the “Initiation of New Services” Incentive Payment**

In order to be eligible for the provider incentive payment, the provider must have capacity to provide the full schedule of those services as outlined in the member’s PCSP.

Contracted CHOICES and ECF CHOICES providers for each of the specified service types are eligible for referral incentive payments for:

1. New members: any service recipient that is new to a provider agency (has never previously been served by the agency);
2. Current service recipients initiating new service *types* (for example, a person currently receiving Personal Assistance or CLS who begins receiving Individual Employment Supports); and
3. Prior service recipients placed on “hold” by the MCO due to out-of-community placement only in specific situations:
  - a. The member was out of the community longer than 30 days AND
  - b. The prior provider is unable to accept any new members for services at the time of the request to restart services.

#### **F. Provider Eligibility Criteria for the “Continuity of Care” Incentive Payment**

As indicated above, providers may receive an additional \$500 incentive payment for the continuous provision of services for no less than six months after service initiation. If a service does not remain in place six months after service initiation, the provider is not eligible for the Continuity of Care incentive payment. The cause of the termination of services is not relevant.

#### **G. Process to Request Incentive Payments**

In order to be eligible for the incentive payment, providers must accept a new referral of a CHOICES or ECF CHOICES member for one of the eligible services above and initiate services for the member. Documentation of such referral acceptance and initiation of services in accordance

with the PCSP will be verified and tracked by the MCOs. In order to receive reimbursement of the referral incentives, providers will be directed to submit a claim as specified by TennCare.

**Retroactive payments:** Providers who have accepted new referrals for services since April 1, 2021 are eligible for retroactive incentive payments. Requests for retroactive incentive payments for April 1, 2021 through August 31, 2021 must be submitted by December 1, 2021.

**Future payments:** Providers are not eligible for payments in advance of initiation of services to a service recipient.

## **H. Attestations and Audits of Provider Incentive Payments**

Prior to participating in the Referral Incentive Program, providers must sign and submit an attestation through PDMS acknowledging understanding of the requirements outlined above and detailed in the attestation form (attached to this memo as Attachment A). In order to ensure the integrity of the incentive payments, audits of the provider incentive payments will occur semi-annually. Any provider who received an incentive payment erroneously will be subject to recoupment upon conclusion of the audit through an offset of the providers claim payments.

**Note:** Any indication that provider agencies are engaging in activities to maximize incentive payments by moving members from one agency to another will be reported to the TennCare Office of Program Integrity, the TBI, and Tennessee Attorney General's office for an investigation related to violation of the False Claims Act.<sup>4</sup>

## **I. Reporting**

On a monthly basis, MCOs will submit a report reflecting the total number and amount of incentive payments made to providers. This report will be submitted on a form to be specified by TennCare including:

- a. Member's name;
- b. DOB;
- c. Service;
- d. Date of referral;
- e. Date of service initiation; and
- f. Whether service has been in place at least six months or outcomes were met (related to applicable employment incentives)

## **J. References**

- Section 9817 of the American Rescue Plan Act of 2021 (ARPA) (Pub. L. 117-2);

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<sup>4</sup> See <https://www.tn.gov/content/dam/tn/tenncare/documents2/pi08001.pdf>.

- Guidance set forth in SMD# 21-003, issued on May 13, 2021 (<https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>);
- Tennessee ARPA FMAP Initial Spending Plan (<https://www.tn.gov/content/dam/tn/tenncare/documents/ARPAEnhancedFMAPPlanForHCBS.pdf>)